

D Neuro Amyotrophic Lateral Sclerosis Als

Record ID

1. Gold Standard Diagnosis

Does the patient meet the diagnostic criteria for Amyotrophic Lateral Sclerosis (ALS) based on:

(1) Progressive motor impairment documented by history or repeated clinical assessment, preceded by normal motor function;

- ☐ Yes
☐ No
☐ Not certain

(2) presence of UMN and LMN signs in at least 1 body region (with UMN and LMN dysfunction noted in the same body region if only one body region is involved) or LMN dysfunction in at least 2 body regions;

- ☐ Yes
☐ No
☐ Not certain

(3) investigations excluding other disease processes.

- ☐ Yes
☐ No
☐ Not certain

Does the patient meet the diagnostic criteria for Amyotrophic Lateral Sclerosis (ALS) based on the criteria above?

2. Type of ALS

Specify the type of ALS in the patient:

- ☐ Sporadic ALS
☐ Familial ALS
☐ Spinal/limb-onset ALS
☐ Bulbar-onset ALS

If you selected "Familial ALS", please specify the genetic mutation if known:

3. Etiology

What is the suspected or known etiology of ALS in the patient?

- ☐ Genetic factors
☐ Environmental factors

Genetic Factors

- ☐ C9orf72 mutation
☐ SOD1 mutation
☐ Other genetic factors

If you selected "Other genetic factors", please specify:

If you selected "Environmental factors", please specify:

4. Clinical Presentation

Describe the clinical features and symptoms of ALS in the patient:

- ☐ Upper Motor Neuron Signs (e.g., spasticity, hyperreflexia)
- ☐ Lower Motor Neuron Signs (e.g., muscle weakness, atrophy, fasciculations)
- ☐ Bulbar Symptoms (e.g., dysarthria, dysphagia)
- ☐ Respiratory Involvement

5. Disease Progression

Please provide information on the current stage and progression of ALS:

- ☐ Early Stage
- ☐ Intermediate Stage
- ☐ Advanced Stage

6. Neurological Assessment

Please provide results from relevant neurological assessments:

Revised ALS Functional Rating Scale (ALSFRS-R) score:

Forced Vital Capacity (FVC) percentage (if measured):

Other neurological assessment (please specify):

7. Imaging and Diagnostic Tests

Electromyography (EMG) and Nerve Conduction Studies (NCS):

Magnetic Resonance Imaging (MRI) of the brain and spinal cord:

Lumbar Puncture (if performed, specify findings):

Genetic testing (if applicable, specify results):

Other diagnostic tests (please specify):

8. Treatment and Management

Has the patient undergone any treatment or interventions for ALS?

- ☐ Yes
- ☐ No

Yes

- ☐ Medications
- ☐ Supportive Care

Medications (if applicable):	<input type="checkbox"/> Riluzole <input type="checkbox"/> Edaravone <input type="checkbox"/> Sodium phenylbutyrate/taurursodiol <input type="checkbox"/> Tofersen <input type="checkbox"/> Symptomatic treatment (e.g., for spasticity, pain) <input type="checkbox"/> Other
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If you selected "Other", please specify:

Supportive Care:	<input type="checkbox"/> Physical therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Speech therapy <input type="checkbox"/> Respiratory support (e.g., non-invasive ventilation) <input type="checkbox"/> Nutrition and swallowing support <input type="checkbox"/> Psychotherapy <input type="checkbox"/> Other
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If you selected "Other", please specify:
